

HOW TO APPLY:

1. Indicate the date you want coverage to begin. (Note: must be within 30 days of signature date.)
2. Choose your deductible.
3. Choose the benefit period you need.
4. Indicate who will be covered.
5. **IMPORTANT:** Be sure to answer all of the Questions.
6. Return your signed application **along with premium for the entire period of coverage.** (Application must be completed in ink.)
7. If paying by check, make payable to **Celtic Insurance.**

Note: Metered mail is not an acceptable postmark



IMPORTANT NOTE:

The information found in this brochure and in any accompanying literature is not intended to provide full details of The Celtic Short-Term Health Plan. Complete terms of coverage are outlined in the Certificate Booklet or Policy, and set forth in the applicable group insurance Policy and Trust agreement. (If you would like a copy of the Certificate Booklet or Policy to review, please contact Celtic.) The information contained in this sales brochure may be subject to change at the discretion of Celtic Insurance Company. In applying for coverage, the participants agree to be bound by the Policy. The benefits described in this brochure and any accompanying literature are the standard benefits offered by Celtic. Policy revisions may vary in some states.

Celtic Short-Term Health Plan Underwritten and Administered
by Celtic Insurance Company
P.O. Box 26110
Little Rock, AR 72221
1-800-477-7990
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Short-Term[®] Health Plan



Earning Your Trust, Every Day

CELTIC SHORT-TERM APPLICATION

INFORMATION ABOUT YOUR COVERAGE:

Requested effective date: ____/____/____
 (Note: The 29, 30 and 31 of the month are not eligible effective dates. Cannot be on or before the postmark date.)
 Requested benefit period: (Circle the number of months) 1 2 3 4 5 6
 Premium for certificate/policy: \$ _____

Deductible per person: (circle one) \$500 \$1,000 \$2,500
 QuitCoverage authorization code: _____
 Have you and/or any dependent to be covered previously applied for insurance with Celtic? YES* NO
 If yes, please provide the certificate(s)/file numbers: _____
 *QuitCoverage cannot be granted over the phone, please mail in your application

FOR OFFICE USE ONLY
 Effective Date: ____/____/____
 Postmark Date: ____/____/____
 Initials: _____

INFORMATION ABOUT YOURSELF:

(For dependent-only coverage the parent/guardian must sign the application and complete the health information for the child.)

Insured's Name: _____ Resident Address: _____ City _____ State _____ Zip _____
 Social Security Number: _____

Birthdate: ____/____/____ Age: _____ Sex: Male Female Telephone Number: _____

INFORMATION ABOUT YOUR FAMILY:

Are any of your dependents to be covered by this certificate/policy? YES NO If YES, please give details below for those to be covered: (Note: Full-time students must be under age 25.)
Dependent name **Relationship to you** **Birthdate (Mo/Day/Yr)** **Sex (M/F)** **Full time student (Yes/No)** **Social Security #**

 spouse
 child
 child

Is everyone to be insured a U.S. Citizen or a foreign resident living in the United States for at least 2 years? YES NO

(If a foreign resident, please submit a copy of your Alien Registration Receipt Card or "Green Card.")

HEALTH QUESTIONS:

If you answer YES to any question below, coverage cannot be issued.

- 1. Do you or any dependents to be covered have any hospital, major medical, group health, government or medical insurance coverage that will not terminate prior to the effective date of this coverage? YES NO
- 2. Are you, your spouse, or any dependent now pregnant or an expectant parent? YES NO
- 3. Have you or any dependent to be covered ever received any medical or surgical consultation, advice, treatment, or medication for:
 - Cancer or tumors YES NO
 - Diabetes YES NO
 - Heart attack, Angina, or other heart disorder YES NO
 - Stroke YES NO

• Excessive use of alcohol or alcoholism YES NO
 • Drug abuse, dependence or addiction YES NO
 • Emotional, psychological, psychiatric, or nervous condition or disorder YES NO
 4. Have you or any dependents to be insured ever been diagnosed as having acquired immune system disorders; or ever tested positive for antibodies to Human Immunodeficiency Virus (HIV)? YES NO

Payment: Check Visa® MasterCard® Discover®
 Exp. Date: ____/____/____ (Credit card option not available in AL)
 Account Number: _____
 Authorized Signature: _____
 Payor Name (Please Print): _____
 Relationship to Applicant: _____

PLEASE READ, SIGN AND DATE: To the best of my knowledge and belief, I have read the application and represent that the information shown on it is true and complete. I understand that the Certificate or Policy applied for will not pay benefits for any expense incurred on account of any pre-existing conditions, in accordance with the terms of the contract. I understand that I/we

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false, incomplete or deceptive statement may be guilty of an insurance fraud.
 Applicant's Signature: _____
 Dated and Signed at: _____ City _____ State _____
 On ____/____/____ Date

SUBMIT TO:
 Celtic Insurance Co.
 P.O. Box 26110
 Little Rock, AR 72221

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AGENT INFORMATION STATEMENT: I certify that I have truly and accurately recorded the information given to me by the applicant. I understand that I represent the interest of the applicant for insurance, NOT Celtic, and have advised my client not to terminate any existing coverage until receiving notice that coverage being applied for by this application is accepted.

Agent Name: **Tony Novak**

Company: **NAIC #2048780**

Agent Signature: _____
 City, State, Zip: _____
 Social Security or Tax ID#: _____
 State of Agent's Permanent License: _____
 Address: _____